Medical Supplies List

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Instructions for the Medical Supplies List

The list which follows describes medical supplies covered by Utah's Medicaid program and conditions of coverage. However, coverage and the Medicaid Prior Authorization requirements apply **ONLY** to medical supplies and equipment to be provided to a Medicaid client assigned to a Primary Care Provider or not enrolled in a managed care plan, or when the supplies/equipment are not included in the Medicaid contract with the managed care plan. Medicaid does **NOT** process Prior Authorization requests for supplies/equipment to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the supplies/equipment are included in a contract with a managed care plan. Providers requesting PA for supplies/equipment to a client enrolled in a managed care plan will be referred to that plan. The list is updated by Medicaid Information Bulletins until republished in its entirety. Below is an explanation of each column and codes on the table.

CODE This is the Health Common Procedure Code System (HCPCS) code used by Medicaid to identify the item or the "Y" code assigned by Medicaid. The item is for purchase, or lease/rental, or either purchase or lease/rental as identified by the codes below. Reference: SECTION 2, Medical Supplies, Chapter 4, PURCHASE OR RENTAL OF EQUIPMENT

Purchase only: No code letters follow the item number code.

Example: Sample code reimbursed for purchase only — A4245

Purchase or Rental: Code *P or RR* below the item code number indicates the item may be reimbursed for either purchase or lease/rental.

Example: Sample code reimbursed for either purchase or lease/rental. — E0164 P or RR

Lease/Rental: Code letters *LL* means the item is a capped rental after 12 months of rental. Medicaid considers the item purchased and no more rental reimbursement is allowed. New equipment must be placed at the beginning, during or at the capped 12 month conversion to a purchase.

Example: Sample code reimbursed for either purchase or lease/rental. — **E0260LL**

DESCRIPTOR This is the description used by the Health Common Procedure Code System (HCPCS), or if a 'Y' code, the description used by Medicaid to identify the item

AGE When this column is blank, Medicaid covers the item from birth through any age. If there are age limits, these are entered numerically. The patient's age on the date of service must be within the age range specified. For example, "0 - 20" means for ages from birth through age 20.

CRITERIA & INSTRUCTIONS Specific information and criteria required by Medicaid before the item will be reimbursed.

PA **P**rior **A**uthorization is required by Medicaid when either of the following codes is entered in this column. Reference: SECTION 2, Medical Supplies; Chapter 6, PRIOR AUTHORIZATION
T - Telephone Prior Authorization
W - Written Prior Authorization.

LTC Indicates coverage for a resident of a long term care facility: When the column is blank, the item is NOT reimbursable for a resident of a long term care facility. A 'Y' indicator in this column means the item is allowed for reimbursement for a resident. Reference: SECTION 2, Medical Supplies; Chapters 1, MEDICAL SUPPLIES, 2 - 1, Nutritional Products; 2 - 2, Parenteral and Enteral Nutrition Therapy; 2 - 7, Oxygen and Related Respiratory Equipment; 2 - 8, Monitoring Equipment; 2 - 9, Wheelchairs and 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY.

COMMENTS & LIMITS Indicates the allowable number of times the item may be reimbursed and other pertinent information. Exceeding the stated limit requires medical necessity and a prior authorization. Reference: SECTION 2, Medical Supplies, Chapter 3, LIMITATIONS

KEY TO DISTINGUISHING CODE CHANGES:
New codes are in **bold print**.
A vertical line in the margin, like the example to the left, marks where text was changed or added.
An asterisk (*) in the margin marks where a code was deleted.

FIRST AID SUPPLIES, WIPES, SWABS

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2, SCOPE OF SERVICE; Chapter 3, LIMITATIONS

CODE	DESCRIPTOR	AGE	Criteria & Instructions	PA	LTC	COMMENTS & LIMITS
A4450	Tape, Non-waterproof, per 18 square inches					
A4452	Tape, waterproof, per 18 square inches					
A4245	Alcohol wipes, per box					2 per month
A4247	Betadine or iodine swabs/wipes, per box					2 per month
A4319	Sterile Water, irrigation, 1000 ml		Limited to recipients on the technology dependent waiver program only.			Up to 30 liters per month
A4455	Adhesive remover					
A6430	Light compression bandage (elastic bandage) 3-5 inch width					2 per month
A6434	Medium compression bandage (elastic bandage) 3-5 inch width					2 per month
A4521	Adult-Sized incontinence product, Diaper, Small Size, Each (Not for adult incontinence without a related disability)		Limit may be exceeded up to 312 for recipients on a waivered program			156 per month
A4522	Adult-sized incontinence product, diaper, Medium size, each (Not for adult incontinence without a related disability)		Limit may be exceeded up to 312 for recipients on a waivered program			156 per month
A4523	Adult-sized incontinence product, diaper, large size, each (Not for adult incontinence without a related disability)		Limit may be exceeded up to 312 for recipients on a waivered program			156 per month
A4524	Adult-sized incontinence product, diaper, extra large, each (Not for adult incontinence without a related disability)		Limit may be exceeded up to 312 for recipients on a waivered program			156 per month
A4529	Child-sized incontinence product, diaper, small/medium size, each (Not for adult incontinence without a related disability)		Limit may be exceeded up to 312 for recipients on a waivered program			156 per month
A4530	Child-sized incontinence product, diaper, large size, each (Not for adult incontinence without a related disability)		Limit may be exceeded up to 312 for recipients on a waivered program			156 per month
A4533	Youth-sized incontinence product, diaper, small/medium size, each (Not for adult incontinence without a related disability)		Limit may be exceeded up to 312 for recipients on a waivered program			156 per month
A4535	Disposable liner/shield for incontinence, each (Not for adult incontinence without a related disability)	age 7 and older	not to be billed in addition other incontinent codes			156 per month Limit may be exceeded up to 312 for recipients on a waivered program
A4536	Protective underwear, washable any size (for use with A4535, liner/shield)	age 7 and older				2 per six months

CODE	DESCRIPTOR	AGE	Criteria & Instructions	PA	LTC	COMMENTS & LIMITS
A4554	Disposable underpads, all sizes, (for example Chux's) Not for bed wetting	age 7 and older	These are available only for medical diagnoses or disease.			200 a month.
A4565	Sling					
A4590	Special Casting Material (Fiberglass)					
A4927	Gloves, non-sterile, per 100		Limit may be exceeded up to 3 boxes per months for recipients on a waivered program			one box per month
A4930	Gloves, sterile, per pair					10 pair per month
A5122	Skin barrier, solid, 8x8, or equiv. each					
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each					
A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. But less than or equal to 48 sq. In., without adhesive border, each					
A6404	Gauze, non-impregnated, sterile, pad >48 sq. in, without adhesive border, each					
S6222	Gauze, impregnated with other than water, normal saline, hydrogel, pad size 16 sq. in. or less,, with adhesive border.					
S6223	Gauze, impregnated with other than water, ns, hydrogel, pad size <16 sq. in. but > 48 sq. in., with adhesive border.					
S6224	Gauze, impregnated with other than water, ns, hydrogel, pad size. < 48 sq. in., with adhesive border.					
A6422	conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 3 inches and less than 5 inches per roll (at least 3 yards, unstretched)				Y	one per day
A6424	conforming bandage, non-elastic, knitted/woven, non-sterile, width equal to or greater than 5 inches per roll (at least 3 yards, unstretched)				Y	One per day
A6426	conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 3 inches and less than 5 inches per roll (at least 3 yards, unstretched)				Y	One per day
A6428	conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 5 inches per roll (at least 3 yards, unstretched)				Y	One per day

*

COMPRESSION GARMENTS AND STOCKINGS

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 3, LIMITATIONS; Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A4490	Surgical stockings above the knee length, each					2 pair every 6 months
A4495	Surgical stockings thigh length, each					2 pair every 6 months
A4500	Surgical stockings below knee length, each					2 pair every 6 months
A4510	Surgical stockings full length, each					2 pair every 6 months
A6510	Compression burn garment, Trunk, including arms down to leg openings, custom fabricated			W		2 pair every 6 months
A6511	Compression burn garment, lower Trunk,including legs , custom fabricated			W		2 pair every 6 months
A6512	Compression burn garment, not other classified, custom fabricated			W		2 pair every 6 months
S8424	Gradient pressure aid (Sleeve), ready made			W		
S8428	Gradient pressure aid (Gauntlet) ready made			W		

*

URINARY CATHETERS

	CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
	A4310	Insertion tray without drainage bag and without catheter					Accessories only
	A4311	Insertion tray without drainage bag, with indwelling catheter, foley type, two way latex with coating					Teflon, silicone, silicone elastomer, or hydrophilic
	A4312	Insertion tray without drainage bag with indwelling catheter foley type, two-way, all silicone					
	A4313	Insertion tray without drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation					
	A4314	Insertion tray with drainage bag with indwelling catheter, foley type, two-way latex with coating					2 per month. Teflon, silicone, silicone elastomer or hydrophilic, etc.
	A4315	Insertion tray with drainage bag with indwelling catheter, foley type, two-way, all silicone					2 per month
	A4316	Insertion tray with drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation					2 per month
	A4320	Irrigation tray for bladder irrigation with bulb or piston syringe, any purpose					4 per month
	A4324	Male external catheter, with adhesive coating, each					
	A4325	Male external catheter, with adhesive strip, each					
	A4326	Male external catheter specialty type, e.g. inflatable, faceplate, etc. each					
	A4327	Female external urinary collection device, meatal cup, each					
	A4328	Female external urinary collection device; pouch, each					
*	A4334	Urinary catheter anchoring device, leg strap, each					
	A4340	Indwelling catheter; specialty type, for example, coude, mushroom, wing, etc.					
	A4344	Indwelling catheter, foley type, two-way all silicone					2 per month
	A4346	Indwelling catheter; foley type, three-way for continuous irrigation					2 per month
	A4347	Male external catheter with or without adhesive, with or without anti-reflux device; per dozen					36 per month
	A4348	Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month)					Teflon, silicone, silicone elastomer, or hydrophilic, etc.
	A4351	Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each					100 per month

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	P A	L T C	COMMENTS & LIMITS
A4352	Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each					100 per month
A4354	Insertion tray with drainage bag but without catheter					
A4355	Irrigation tubing set for continuous bladder irrigation through a three-way indwelling foley catheter, each					
A4356	External urethral clamp or compression device (not to be used for catheter clamp), each					
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each					
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each					
A4359	Urinary suspensory without leg bag, each					3 per month
A4398	Irrigation supply; bag, each					30 per month
A4399	Irrigation supply; cone/catheter, includes brush					6 per month
A4860	Disposable catheter tips for peritoneal dialysis, per 10					
A5102	Bedside drainage bottle, rigid or expandable, with or without tubing; each					
A5105	Urinary suspensory; with leg bag, with or without tube					
A5112	Urinary leg bag; latex					
A5113	Leg strap; latex, per set					
A5114	Leg strap; foam or fabric, per set					
E0276	Bed pan, fracture, metal or plastic					
E0325	Urinal; male, jug-type, any material					

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OSTOMY SUPPLIES

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

	CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
	A4361	Ostomy faceplate					
	A4362	skin barrier, solid 4x4 or equivalent, each					10 per month
	A4364	Adhesive for ostomy or catheter; liquid (spray, brush, etc.) cement, powder or paste; any composition (E.g., silicone, latex, etc.); per oz					
*	A4367	Ostomy belt					
	A4369	Skin barrier; liquid (spray, brush, etc.).					4 per month
	A4371	Skin barrier, powder, per oz					4 oz per month
	A4375	Pouch, drainable; with faceplate attached; plastic					
	A4376	Pouch, drainable; faceplate attached; rubber (ea)					
	A4377	Pouch, drainable; use on faceplate, plastic (ea)					1 piece
	A4378	Pouch, drainable, use on faceplate, rubber (ea)					
	A4379	Pouch, urinary; with faceplate attached; plastic (ea)					
	A4380	Pouch, urinary, with faceplate attached, rubber (ea)					
	A4382	Pouch, urinary, with faceplate attached, heavy plastic (ea)					
	A4383	Pouch, urinary, use on faceplace, rubber (ea)					
	A4384	Ostomy faceplate equivalent, silicone ring, (ea)					
	A4385	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each					
*	A4387	Ostomy pouch closed, with standard wear barrier attached, with built-in convexity (1 piece), each					
	A4388	Ostomy pouch, drainable; ext wear with barrier attached					
	A4389	Ostomy pouch, drainable, with standard wear barrier attached, with built-in convexity (1 piece), each					
	A4390	Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each					
	A4391	Ostomy pouch, urinary, with extended wear barrier attached, without built-in convexity (1 piece), each					
	A4392	Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each					
	A4393	Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each					
	A4400	Ostomy irrigation set					2 per month
	A4404	Ostomy rings, each					
	A4407	Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4x4 inches or smaller, each					
	A4455	Adhesive remover or solvent (for tape, cement or other adhesive) per ounce					2 per month
	A5051	Ostomy pouch, closed; with barrier attached (1 piece)					
	A5052	Ostomy pouch, closed; without barrier attached (1 piece)					
	A5053	Ostomy pouch, closed; for use on faceplate					

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A5054	Ostomy pouch, closed; for use on barrier with flange (2 piece)					
A5055	Stoma cap					
A5062	Ostomy pouch, drainable; without barrier attached (1 piece)					20 per month
A5063	Ostomy pouch, drainable; for use on barrier with flange; 2 piece system					
A5072	Ostomy pouch, urinary; without barrier attached					1 piece
A5073	Ostomy pouch, urinary; or use on barrier with flange					2 piece
A5081	Continent device; plug for continent stoma					
A5082	Continent device; catheter for continent stoma					
A5093	Ostomy accessories, convex insert					
A5119	Skin barrier; wipes, box per 50					
A5126	Adhesive or non-adhesive; ; disc or foam pad, each					
K0591	Ostomy Pouch, urinary, with extended wear barrier attached, with facet-type tap with valve, each					1 per month

*

SYRINGES

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2 - 2, Parenteral and Enteral Nutrition Therapy; Chapter 2 - 3, I.V. Therapy; Chapter 2 - 4, Enteral, Parenteral and I.V. Therapy Pumps; Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A4206	Syringe with needle, sterile 1cc each					100 per month
A4207	Syringe with needle, sterile 2cc					100 per month
A4208	Syringe with needle, sterile 3cc					100 per month
A4210	Needle-free injection device					1 per lifetime
A4212	Non-coring needle or stylet; with or without catheter					30 per month
A4213	Syringe, sterile 20cc or greater					30 per month
A4215	Needles only, sterile, any size					100 per month
S8490	Insulin Syringe					100 per month

MISCELLANEOUS SUPPLIES

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A4214	Sterile saline or water, 30cc vial					
A4250	Urine test or reagent strips or tablets (100 tablets or strips)					2 per month
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips					4 per month
A4258	Auto/lancet device, each					
A4259	Lancets, per box of 100					2 per month
A4260	Levonorgestrel contraceptive implant system, including implant and supplies (Norplant)	age 12 & older			Y	
A4570	Splint					
A4580	Cast supplies (e.g. plaster)					
A4614	Peak expiratory flow rate meter, hand held					1 per year
A4660	Sphygmomometer-blood pressure apparatus with cuff and stethoscope					1 every 5 years
A4663	Blood pressure cuff only					1 every 5 years
A4670	Automatic blood pressure monitor		1. Physician order with diagnosis. 2. Letter of medical necessity documenting medical need for the client's blood pressure to be continuously recorded.	W		Purchase only
A4772	Blood glucose test strips, for dialysis, per 50					4 per month. Each unit = 1 box of 50 (such as chemstrips BG visidex, etc.)
A4773	Occult blood test strips, for dialysis, per 50					4 per month. Each unit = 1 bottle of 50 (for occult blood)
E0200	Heat lamp, without stand (table model) includes bulb, or infrared element					
E0202RR	Phototherapy (bilirubin) light with photometer					7 days maximum rental per week
E0602	Breast pump, manual, any type					Electric pumps are not covered.
* **A4483**	Moisture exchanger, disposable (artificial nose)					30 per month

ENTERAL, PARENTAL NUTRITION

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2 - 1, Nutritional Products; Chapter 2 - 2, Parenteral and Enteral Nutrition Therapy; Chapter 2 - 3, I.V. Therapy; Chapter 2 - 4, Enteral, Parenteral and I.V. Therapy Pumps; Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
B4034	Enteral feeding supply kit; syringe, per day			T		1 per day. Includes feeding syringes, tape, wipes.
B4035	Enteral feeding supply kit; pump fed, per day		1. Physician order. 2. Must be using infusion pump for enteral feeding.	T		1 per day. Includes pump sets, bags, containers, syringes, tapes, wipes.
B4036	Enteral feeding supply kit; gravity fed, per day			T	Y	1 per day. Includes containers, tape, wipes, tubing.
B4081	Nasogastric tubing with stylet				Y	3 per month. For example Transorb, Entiflex, Dobb Huff, Flexiflow, etc.
B4086	Gastrostomy / jejunostomy tube, any material, any type, (standard or low profile), each				Y	3 per month
B4220	Parenteral nutrition supply kit, premix, per day					1 per day. Includes gloves, alcohol wipes, Iso. alcohol, acetone, povidone, iodine scrub, povidone iodine, iodine ointment, povidone swabs, povidone sticks, gauze sponges, heparin flush, micropore tape, plastic tape, injection caps, syringes, needles, Ketodiastix, Dextrostix.
B4222	Parenteral nutrition supply kit, home mix, per day		1. Physician order. 2. Home bound patient			1 per day
B4224	Parenteral nutrition administration kit, per day					1 per day. Includes admin sets/leur lock and micron filter, pump, cassettes, clamps, extension sets, 2 or 3 way connectors.
B9002RR	Enteral nutrition infusion pump-with alarm		1. Physician order. 2. Client must be on enteral feeding. 3. Diagnosis of aspiration, diarrhea, dumping syndrome	T	Y	per day
B9006RR	Parenteral nutrition pump, stationary		1. Physician order. 2. Must be on TPN.	W	Y	per day
E0776 P or LL	I.V. pole					Rental per month

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
*	Gastronomy buttons and tubing (Mic-key buttons)		Bill using B9998, NOC (Not Otherwise Covered) for enteral supplies, specify the brand name used and price.			4 per year

NUTRIENTS

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2 - 1, Nutritional Products; Chapter 2 - 2, Parenteral and Enteral Nutrition Therapy; Chapter 2 - 3, I.V. Therapy; Chapter 2 - 4, Enteral, Parenteral and I.V. Therapy Pumps; Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
B4100	Food Thickener, Administered orally		Per ounce			
B4150	Enteral formulae; category I: Semi-synthetic intact protein/protein isolates, administered through an enteral feeding tube. 100 calories = 1 unit. For example,Enrich, Ensure, Ensure HN, Ensure Powder, Isocal, Jevity, Lonalac powder, Meritene, Meritene powder, Osmolite ,Osmolite HN, Pediasure (thru age 10 only), Portagen powder, Pre-Attain, Profiber, Pulmocare, Renu, Resource, Sustacal. (Pediasure as total nutrition or a supplement is available through WIC for children 5 years and under.)		The following criteria apply to ALL nutrients. Enteral nutrients are liquid formulas supplied within the intestine. 1. Diagnosis related to need for enteral nutrition. 2. No other food intake/total nutrition. 3. Functional impairment; i.e. missing or nonfunctioning portions of the GI system. 4. Enteral nutrition given by NG, NJ, GT, JT. 5. Patient has neurological or psychological impairment that prevents swallowing, which is functional impairment. 6. Doctor's orders: name of product, dose and frequency or total amount per day All prescription changes require a telephone Prior Authorization and will be effective on the date of the telephone call to the Prior Authorization unit.	T	Y	
B4151	Enteral formulae;category I: natural intact protein/protein isolates, administered through an enteral feeding tube. 100 calories = 1 unit. (e.g., Complete B, Vitaneed, Complete B modified)		Same as B4150	T	Y	
B4152	Enteral formulae; category II: intact protein/protein isolates, administered through an enteral feeding tube. 100 calories = 1 unit. (e.g., Deliver 2.0, Magnacal, Isocal HN, Sustacal HC, Ensure Plus, Ensure plus HN).		Same as B4150	T	Y	
B4153	Enteral formulae; category III: hydrolyzed protein/amino acid, administered through an enteral feeding tube. 100 calories = 1 unit. (e.g., Travasorb HN, Isotein HN, Precision HN, Precision Isotonic (e.g., Criticare HN, Vivonex TEN,. Vivonex HN, Vital (Vital HN)		Same as B4150	T	Y	
B4154	Enteral formulae; category IV: defined formula for special metabolic need, administered through an enteral feeding tube. 100 calories = 1 unit. (e.g.,Aminaid, Hepatic-Aid, Peptamin, Travasorb Hepatic, Traum-Aid, Tramacal, Travasorb MCT, Travasorb Renal,)		Same as B4150	T	Y	
B4155	Enteral formulae; category V: modular components (protein, carbohydrates, fat), administered through an enteral feeding tube. 100 calories = 1 unit. (e.g., Propac, Promix, Casec , Moducal, Polycose liquid or powder, Sumacal, Microlipids, MCT oil)		Same as B4150	T	Y	
B4156	Enteral formulae: category VI: standardized nutrients, administered through an enteral feeding tube. (Vivonex STD, Travasorb STD, Precision LR and Tolerex) 100 calories = 1 unit		Same as B4150	T	Y	

	CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
*	**PKU**	All PKU nutrition must be billed using NDC and is not open to medical suppliers.					
	B4164	Parenteral nutrition solution: carbohydrates (dextrose) 50% or less		(500 ML = 1 unit) homemix		Y	
	B4168	Parenteral nutrition solution: Amino Acid, 3.5%		(500 ML = 1 unit) homemix		Y	
	B4172	Parenteral nutrition solution : amino acid, 5.5% through 7%		(500 ML = 1 unit) homemix		Y	
	B4176	Parenteral nutrition solution: amino acid, 7% through 8.5%,		(500 ML = 1 unit) homemix		Y	

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
B4178	Parenteral nutrition solution: amino acid, greater that 8.5%		(500 ML = 1 unit) homemix		Y	
B4180	Parenteral nutrition solution: carbo-hydrates (dextrose), greater than 50%		(500 ML = 1 unit) homemix		Y	
B4184	Parenteral nutrition solutions: lipids, 10% with administration set		(500 ML = 1 unit)		Y	30 per month
B4186	Parenteral nutrition solution, lipids, 20% with administration set		(500 ML = 1 unit)		Y	30 per month
B4189	Parenteral nutrition solution; compound amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein. premix		10 to 51 grams in divided or single doses = one unit		Y	1 unit per day
B4193	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein. premix		52 to 73 grams in divided or single doses = one unit		Y	1 unit per day
B4197	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength 74 to 100 grams of protein. premix		74 to 100 grams in divided or single doses = one unit		Y	1 unit per day
B4199	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein. premix		over 100 grams in divided or single doses = one unit		Y	1 unit per day
B4216	Parenteral nutrition additives (vitamins, trace elements, heparin, electrolytes) homemix per day. (each day = 1 unit)				Y	30 per month
B5000	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, Renal - Aminosyn RF, Nephramine, Renamine. premix (each day = 1 unit)		No additives, only total nutrition in a long term care facility or home.		Y	30 per month
B5100	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, Hepatic - Freamine HBC, Hepatamine. premix. (each day = 1 unit)		No additives, only total nutrition in a long term care facility or home.		Y	30 per month
B5200	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids. premix		No additives, only total nutrition in a long term care facility or home.		Y	30 per month

I. V. SUPPLIES

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2 - 1, Nutritional Products; Chapter 2 - 2, Parenteral and Enteral Nutrition Therapy; Chapter 2 - 3, I.V. Therapy; Chapter 2 - 4, Enteral, Parenteral and I.V. Therapy Pumps; Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

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Reserved for future use

PUMPS

Reference: SECTION 2, Medical Supplies, Chapter 2 - 4, Enteral, Parenteral and I.V. Therapy Pumps

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
* **S5520**	Home infusion therapy, all supplies (including catheter)necessary for a peripherally inserted central venous catheter (PICC) line insertion (Includes all supplies, needles, catheter, dressings etc., but does not include nursing services)				Y	1 per week
S5521	Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion (Includes all supplies, needles, catheter, dressings etc., but does not include nursing services)		May also be used for short peripheral IV of 2-5 days of administration		Y	1 per week
S1015	IV tubing extension set		May be billed with S5520 or S5521		Y	15 per month
Category 1: Totally disposable units - nonelectronic						
A4305	Disposable Drug Delivery System, flow rate greater than 50 ml per hour (includes all supplies and needles–do not bill with A4221)		1. Physician order; 2. Short term antibiotic therapy with diagnosis, dosage, frequency, and length of therapy; 3. Must be ambulatory to attend school or work.	T	Y	3 per day
A4306	Disposable Drug Delivery System, flow rate less than 5 ml per hour (includes all supplies and needles–do not bill with A4221)		1. Physician order; 2. Short term antibiotic therapy with diagnosis, dosage, frequency, and length of therapy; 3. Must be ambulatory to attend school or work.	T	Y	3 per day
A4232	Syringe with needle for external. infusion pump, sterile, 3cc each					100 per month.

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CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
Category 2: Insulin pump - insulin specific pump, nonimplanted						
E0784	External ambulatory infusion pump, insulin		1. Physician order from endocrinologist or internist. 2. Diagnosis of insulin dependent diabetes. 3. Outpatient records documenting efforts to control diabetes using at least two insulin injections per day. 4. Glucose monitoring records for three months preceding request for pump with an average of three Blood Sugar measurements per day. Include at least 10 measurements at each of these times during the day: a. A.C. (before meals) b. H.S. (bedtime) c. 0100-0300 Include the dose of insulin given.	W	Y	
A4230	Infusion set, external insulin pump, non needle cannula		For diabetic patient who is allergic to the metal needle which remains inserted into the body. This device inserts a cannula which is non-metal. Not to be billed with A4231		Y	10 per month
A4231	Infusion set for external insulin pump, needle type		Not to be billed with A4230		Y	10 per month
A4232	Syringe with needle for external pump, sterile, 3cc		used as the insulin reservior for E0784		Y	7 per month
Category 3: Stationary pump for patients who are (partially) bed bound						
B9002RR	Enteral nutrition infusion pump-with alarm		1. Physician order. 2. Client must be on enteral feeding. 3. Diagnosis of aspiration, diarrhea, dumping syndrome	T	Y	per day
B4034	Enteral feeding supply kit, syringe fed, per day		1. Physician order. 2. Client has damaged or non-functioning part of the gastric system. 3. Client receiving enteral feeding via a feeding tube for total nutrition.	T	Y	1 per day. Includes, containers, syringes, tapes, wipes.
B4035	Enteral feeding supply kit; pump fed, per day		1. Physician order. 2. Must be using infusion pump for enteral feeding.	T	Y	1 per day. Includes pump sets, containers, syringes, tapes, wipes.
B9006RR	Parenteral nutrition pump, stationary		1. Physician order. 2. Must be on TPN.	W	Y	per day
B4222	Parenteral nutrition supply kit, home mix, per day		1. Physician order. 2. Home bound patient			1 per day

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
B4224	Parenteral nutrition administration kit, per day					1 per day. Includes admin sets/leur lock and micron filter, pump, cassettes, clamps, extension sets, 2 or 3 way connectors.
E0791RR	Parenteral infusion pump, stationary single or multi-channel		1. Physician order 2. Antibiotic therapy with diagnosis, dosage, frequency, chemotherapy, or continuous heparin infusion,and length of therapy. Replacement cartridge included in rental	T	Y	per day
Category 4: Semi-stationary or ambulatory pump for specific product infusion						
E0781RR	Ambulatory infusion pump (such as Maxx or microject), single or multiple channels, with administrative equipment, worn by patient		1. Physician order for one of the following: Chemotherapy, pain management, antibiotics, immunoglobin. 2. Duration of therapy in days	T	Y	rental per day
A4222	Supplies for external drug infusion pump, per cassette or bag (list drug separately)		For use with pumps requiring bags or cassettes, such as E0781, includes supplies, dressings, needles, cannulas, etc.		Y	3 per week unit = one
E0779RR	Ambulatory infusion pump, reuseable, over 8 hours		1. Physician order 2. Use more cost effective 3. Days therapy	T	Y	per day
E0780RR	Ambulatory infusion pump, reuseable, less than 8 hours		Same as E0779	T	Y	per day
A4221	Supplies for maintenance of drug catheter per week		(Includes all supplies, dressing, needles, catheters,sterile change kits, flushing supplies, and maintenance, etc. Use with E0779 or E0780)			One per week
S1015	IV tubing extension set		May be billed with A4211 for tubing		Y	15 per month
A4305	Disposable Drug Delivery System, flow rate greater than 50 ml per hour		1. Physician order; 2. Short term antibiotic therapy with diagnosis, dosage, frequency, and length of therapy; 3. Must be ambulatory to attend school or work.	T		
A4306	Disposable Drug Delivery System, flow rate less than 50 ml per hour		1. Physician order; 2. Short term antibiotic therapy with diagnosis, dosage, frequency, and length of therapy; 3. Must be ambulatory to attend school or work.	T		

AMBULATION DEVICES

Reference: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A4635	Underarm pad, crutch, replacement, each					
A4636	Replacement, handgrip, cane, crutch or walker each					
A4637	Replacement, tip, cane, crutch, walker, each					
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip					
E0105	Cane, quad or three prong, includes canes of all material, adjustable or fixed with tips					
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and hand grips					
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each with tip and hand grips					
E0112	Crutches, underarm, wood, adjustable or fixed, pair with pads tips and hand grips					
E0113	Crutches, underarm, wood, adjustable or fixed, each with pad tip and hand grips					
E0114	Crutches, underarm, aluminum, adjustable or fixed, pair, with pads tip and handgrips					
E0116	Crutches, underarm, aluminum, adjustable or fixed, each, with pad, tip and handgrips					
E0130 P or LL	Walker, rigid (pickup), adjustable or fixed height					per month
E0135 P or LL	Walker, folding (pickup), adjustable or fixed height					per month
E0141 P or LL	Walker, wheeled, without seat, rigid					per month
E0143 P or LL	Walker, wheeled, without seat, folding					per month
E0145 P or LL	Walker, wheeled, with seat and crutch attachments					Paid at the same price as E0141. per month
E0148	Walker, heavy duty, without wheels, rigid or folding, any type, each					
E0149	Walker, heavy duty, wheeled, rigid or folding, any type, each					
S8470	Positioning device, stander for use by patient who is unable to stand independently	2-20		Y		

BATHROOM EQUIPMENT

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	P A	LTC	COMMENTS & LIMITS
E0160	Sitz type bath or equipment, portable, used with or without commode					1 every 5 years
E0163 P or LL	Commode chair, stationary, with fixed arms					1 every 5 years rental per month
E0164 P or LL	Commode chair, mobile, with fixed arms					1 every 5 years rental per month
E0165 P or LL	Commode chair, stationary, with detachable arms (pail or pan included)					1 every 5 years rental per month
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each					1 every 5 years rental per month
E0246	Transfer tub rail attachment (not on wall)					1 per lifetime
Y6046	Position support bath system	6 - 20	Physician order Patient endangerment without this sys.	W		1 per lifetime
* **E0244**	Raised toilet seat	0 - 20	Physician order	W		1 every 5 years

DECUBITUS CARE

Reference: SECTION 2, Medical Supplies, Chapter 2 - 5, Decubitus Care: Beds, Pads, Mattresses, and Overlays

CODE	DESCRIPTOR	Age	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient					
A6021	Collagen dressing, pad size 16 sq. In. Or less, each				Y	one daily
A6022	Collagen dressing, pad size more than 16 sq. In. But less than or equal to 48 sq. In., each				Y	one daily
A6023	Collagen dressing, pad size more than 48 sq. In., each				Y	one daily
A6024	Collagen dressing wound filler, per 6 inches				Y	one daily
A6196	Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. In. or less, each dressing		Algiderm, Algosteril, Curasorb, Kaltostat-Fortex, Kaltostat, Sorbsan		Y	one daily
A6197	Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. In. But less than or equal to 48 sq. In., each				Y	one daily
A6198	Alginate dressing, wound cover, more than 48"sq, each				Y	one daily
A6199	Alginate or other fiber gelling dressing, wound filler, per 6 inches				Y	one daily
A6200	Composite dressing, pad size 16 sq. in. or less, without adhesive border, each				Y	one daily
A6201	Composite dressing, pad size more than 16 sq. in. But less than or equal to 48 sq. in., without adhesive border, each				Y	one daily
A6202	Composite dressing, pad size more than 48 sq. in., without adhesive border, each				Y	one daily
A6209	Foam dressing wound cover, 16" sq. or less, without adhesive back, each		Allevyn, Epigard, Epi-Lock, Hydrasorb, Flexzan, Lyofoam, Lyofoam C, Lyofoam A, Mitraflex Plus, Mitraflex SC, Nu-Derm		Y	one daily
A6210	Foam dressing wound cover, 16" sq. to 48" sq., without adhesive back, each				Y	one daily
A6212	Foam dressing wound cover, 16" sq. or less, with adhesive back, each				Y	one daily
A6213	Foam dressing wound cover, 16" sq. to 48" sq., with adhesive back, each				Y	one daily
A6215	Foam dressing wound filler, per gram		Allevyn Cavity Wound Dressing		Y	once daily
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing				Y	once daily

CODE	DESCRIPTOR	Age	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
A6217	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or more but less than or equal to 48 sq. in., without adhesive border, each dressing				Y	once daily
A6231	Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. In. Or less, each dressing				Y	one daily
A6232	Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. In., but less than or equal to 48 sq. In., each dressing				Y	one daily
A6233	Gauze, impregnated, hydrogel for direct wound contact, pad size more than 48 sq. In., each dressing				Y	one daily
A6234	Hydrocolloid dressing, wound cover, less than 16" sq., without adhesive border		Actiderm, Comfeel, Cutinova Hydro, Dermatell, Duoderm, Hydrapad, Intact, Replicare, Restore, Swen-A-Peel, Tegasorb, Ultec		Y	one daily
A6235	Hydrocolloid dressing, wound cover, 16" to 48" sq., without adhesive border				Y	one daily
A6237	Hydrocolloid dressing, wound cover, less than 16" sq., with adhesive border				Y	one daily
A6238	Hydrocolloid dressing, wound cover, 16" to 48" sq., with adhesive border				Y	one daily
A6240	Hydrocolloid dressing, wound filler paste, per ounce		Comfeel, Duoderm, Replicare, Triad		Y	once daily
A6241	Hydrocolloid dressing, wound filler, dry form, per ounce				Y	one daily
A6245	Hydrogel dressing, wound cover, less than 16" sq., with adhesive border		Actiderm, Comfeel, Cutinova Hydro, Dermatell, Duoderm, Hydrapad, Intact, Replicare, Restore, Swen-A-Peel, Tegasorb, Ultec		Y	one daily
A6246	Hydrogel dressing, wound cover, 16" to 48" sq., with adhesive border				Y	one daily
A6261	Hydrogel dressing, wound filler paste, per ounce		Comfeel, Duoderm, Replicare, Triad		Y	one daily
A6242	Hydrogel dressing, wound cover, less than 16" sq., without adhesive border		Actiderm, Comfeel, Cutinova Hydro, Dermatell, Duoderm, Hydrapad, Intact, Replicare, Restore, Swen-A-Peel, Tegasorb, Ultec		Y	one daily
A6243	Hydrogel dressing, wound cover, 16" to 48" sq., without adhesive border				Y	one daily
A6248	Hydrogel dressing, wound filler, gel, per fluid ounce		Comfeel, Duoderm, Replicare, Triad		Y	one daily
A6254	Speciality absorptive dressing, 16" sq., each with adhesive border		Absorptial		Y	one daily
A6255	Speciality absorptive dressing l, 16" sq. to 48" sq., each with adhesive border		Absorptial		Y	one daily

CODE	DESCRIPTOR	Age	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
A6251	Speciality absorptive dressing, 16" sq. each without adhesive border		Absorptial		Y	one daily
A6252	Speciality absortpive dressing, 16" sq. to 48" sq., each without adhesive border		Absorptial		Y	one daily
A6257	Transparent film, 16" sq. each		Acu-Derm, Bioclusive, Blisterfilm, Dermassist Site Dressing, Ensure-It, Hydrodern, Oprafex, Opsite, Polyskin II, Pro-Clude, Tegaderm, Transeal, Uniflex		Y	one daily
A6258	Transparent film, 16" to 48" sq., each				Y	one daily
A6259	Transparent film, more than 48" sq., each				Y	one daily
E0176	Air pressure pad or cushion, nonpositioning					
E0178	Gel pressure pad or cushion, nonpositioning					
E0179	Dry pressure pad or cushion, nonpositioning (For example, eggcrate)					
E0180 P or RR	Pressure pad, alternating with pump		See criteria for Y6000RR, air fluidation bed with silicone microspheres.	W		same as Y6000RR, except rental per month
E0181 P or RR	Pressure pad, alternating with pump, heavy duty		See criteria for Y6000RR, air fluidation bed with silicone microspheres.	W		same as Y6000RR, except rental per month
E0182 P or RR	Pump for alternating pressure pad (or mattress size)		See criteria for Y6000RR, air fluidation bed with silicone microspheres.	W		same as Y6000RR, except rental per month.
E0185	Gel or gel-like pressure pad for mattress (mattress size)					
E0186	Air pressure mattress (mattress size)					
E0188	Synthetic sheepskin pad					
E0191	Heel or elbow protector, each					
E0192	Low pressure/positioning equalization pad, wheelchair		See criteria listed for Y6000RR, air fluidation bed with silicone microspheres.			
E0193RR	Powered air flotation bed (low air loss therapy)		See criteria listed for Y6000RR, air fluidation bed with silicone microspheres.	W		same as Y6000RR Rental per day.
E0217 P or RR	Water circulating heat pad with pump					per month
E0277RR	Alternating pressure mattress		See criteria listed for Y6000RR, air fluidation bed with silicone microspheres.	W		same as Y6000RR Rental per day.

CODE	DESCRIPTOR	Age	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
E0373	Non-powered advanced pressure relieving mattress		Refer to SECTION 2, Medical Supplies, Chapter 2 - 5, Decubitus Care, items A & B.	W	Y	purchased
Y6000RR	Air fluidation bed with silicone microspheres		Request must include: A. The existence of multiple Stage III and/or Stage IV pressure ulcers, burns or post surgical areas B. Nursing notes, including aggressive management of the patient C. Photographs of client's decubitus area D. Physician documentation including orders and progress notes of the following: 1. Fecal incontinence 2. Diarrhea 3. Caloric and protein intake, and measurements 4. Limited mobility due to: a. Pain b. Contracture c. Spinal cord injury d. Obesity e. Restricted positioning f. Altered consciousness g. Paralysis h. Disease prone i. sedation E. Documented inability to position off lesions F. Documented use of decubitus dressings, including time and description of use.	W	Y	Rental per day. Skin graft = 14 days The bed, mattress or overlay may be approved for 30 days. With documented significant improvement, 30 additional days may be approved for a total of 60 days. With documented improvement, a step down transfer from E0193 or Y6000 only to E0277 or E0180 may be approved for 30 days. With documented aggressive nursing and proof of improvement, a 30-day extension of the E0277 or E0180 may be approved. The maximum treatment with bed and/or mattress is 120 days.
Y6001RR	Water fluidation bed (Rental per day)		Refer to Y6000	W	Y	Either bed may be approved for 30 days. With documented improvement, either may be approved for an additional 30 days. Maximum is 60 days total

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HOSPITAL BEDS and ACCESSORIES

Reference: SECTION 2, Medical Supplies, Chapter 2 - 6, Hospital Beds

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
E0250 P or LL	Hospital bed, fixed height with any type side rails with mattress		Client resides at home, not an institution, care facility, etc. Medical condition is such that client is "bed confined" [80% of time (19-20 hours) is spent in confinement]. Condition necessitates positioning in a way not applicable to an ordinary bed. Condition necessitates attachments to bed which could not be affixed to an ordinary bed.	T		rental per month
E0260LL	Hospital bed, semi electric with any type side rails and mattress		Same as E0250	T		rental per month
E0271	Mattress, innerspring		Replacement for patient owned hospital bed	T		
E0272	Mattress, foam rubber					
E0273	Bed board					
E0305 P or LL	Bed side rails, half length					rental per month
E0310 P or LL	Bed side rail, full length					rental per month
E0196	Gel pressure mattress					
K0549LL	Hospital bed, heavy duty, extra wide, greater the 350 lbs but less than 600 lbs.		Same as E0250	W		

OXYGEN and RELATED RESPIRATORY EQUIPMENT

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2 - 7, Oxygen and Related Respiratory Equipment; Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A4612	Battery cables; replacement for patient owned ventilator					1 every 5 years
A4618	Breathing circuits					8 per month
A7030	Ful face mask used with positive airway pressure device, patient owned			T		One per year
A7031	Face mask interface, replacement for full face mask, each, Patient owned			T		One every 6 months
A7034	Nasal interface (mask or cannula type,) used with positive airway pressure device, Patient owned			T		One every 6 months
A7035	Headgear used with positive airway pressure device, Patient owned			T		One time only
A7037	Tubing used with positive airway pressure device, Patient owned			T		Once every 6 months
A7038	Filter, disposable, used with positive airway pressure device, Patient owned			T		One every 30 days
A7039	Filter, non disposable used with positive airway pressure device, Patient owned			T		One every 30 days
E0424RR	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing (1 unit = 50 cubic ft.)		1. Diagnosis indicating client's ability to breathe is severely impaired. 2. Physician order indicating: liter flow, duration of therapy, frequency (hours per day). 3. Physician documentation to support medical necessity for gaseous oxygen rather than a concentrator. 4. Length of time client will require oxygen.	T		includes 50 cubic feet gaseous oxygen a month; rental per month
E0425	Stationary compressed gas system, includes regulator with flow gauge, humidifier, nebulizer, cannula or mask and tubing		1. Diagnosis indicating client's ability to breathe is severely impaired. 2. Physician order indicating: liter flow, duration of therapy, frequency (hours per day). 3. Physician documentation to support medical necessity for gaseous oxygen rather than a concentrator. 4. Length of time client will require oxygen. 5. Cost effectiveness of purchase versus rental must be documented.	T		Does not include oxygen. For purchase only.

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
E0441	Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned) (1 unit = 50 cubic ft.)		1. Client must own his own stationary system. This includes purchase by Medicaid after 12 months' rental paid. 2. Physician documentation to include diagnosis, liter flow, frequency, and duration of oxygen therapy, and medical necessity for gaseous versus concentrator. FORMULA TO COMPUTE UNITS: (1 unit equals 50 cubic feet) Liter/minute x 60 =___ x 24 hours = ___ x 30 days = ___ x months = ___ x .0353 = _____ cubic feet ÷ 50 = ____ units.	T		Only one system, liquid or gas, approved for a patient. Includes all charges for use of the container.
E0431RR	Portable gaseous oxygen system, rental; includes portable container, regulator, Flowmeter, humidifier, cannula or mask, and tubing		Use of portable gaseous system must be based on a documented medical necessity with a physician's written prescription: 1. Diagnosis indicating the client's ability to breath is severely impaired 2. Liter flow per minute 3. Number of physician visits per month, length of visit and travel time to and from each visit 4. If exercise is prescribed, must specify type of exercise, length of exercise period and number of days per week. (This is exercise away from the stationery oxygen system, i.e., a monitored therapy program) 5. If for transportation to and from school or educational activity, must specify total travel time per day. Portable oxygen will not be provided for use during education activity, or social activity.	T		rental per month
E0443	Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used); 1 unit = 5 cubic ft.		Use of portable gaseous oxygen must be based on a documented medical necessity with a physician's written prescription: 1. Diagnosis indicating the client's ability to breathe is severely impaired. 2. Liter flow per minute. 3. Number of physician visits per months, length of visit and travel time to and from each visit. 4. If exercise is prescribed, must specify type of exercise, length of exercise period and number of days per week. (This is exercise away from the stationary oxygen system, i.e., a monitored therapy program) 5. If for transportation to and from school or educational activity, must specify total travel time per day. Portable oxygen will not be provided for use during education activity or social activity. FORMULA TO COMPUTE UNITS: (1 unit equals 5 cubic feet) Liter/minute x 60 = ___ x hours used =____ x number of days = ____ x months = ____ x .0353 = ____ cubic feet ÷ 50 = _____ units.	T		

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
E0439RR	Stationary liquid oxygen system, rental; includes container, contents. Includes use of reservoir, contents per unit, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing (includes one unit 10 pounds liquid oxygen)		A liquid oxygen system will be approved only under specific circumstances, i.e., when multiple equipment is used in a series such as compressors,ventilators, etc, or when a specific medical need has been established. 1. Diagnosis indicating the client's ability to breathe is severely impaired. 2. Physician order indicating liter flow, frequency, and duration of oxygen therapy. 3. Physician order must indicate what equipment is being used with the liquid oxygen or the specific medical necessity for the liquid oxygen. 4. Length of time client will require oxygen.	T		one unit a month rental per month
E0440	Stationary liquid oxygen system. Includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing (does not include oxygen)		A liquid oxygen system will be approved only under specific circumstances, i.e., when multiple equipment is used in a series such as compressors,ventilators, etc, or when a specific medical need has been established. 1. Diagnosis indicating the client's ability to breathe is severely impaired. 2. Physician order indicating liter flow, frequency, and duration of oxygen therapy. 3. Physician order must indicate what equipment is being used with the liquid oxygen or the specific medical necessity for the liquid oxygen. 4. Length of time client will require oxygen. 5. Cost effectiveness of purchase versus rental must be documented.	T		oxygen not included. For purchase only.
E0442	Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned); 1 unit = 10 lbs.		1. The client must own his own stationary system. 2. Physician documentation to include: diagnosis, liter flow, frequency, duration, medical necessity for liquid oxygen versus gaseous or concentrator. FORMULA TO COMPUTE: (1 unit equals 10 pounds) Liter/minute x .002924 = ___ x 60 = ___ x 24 hours = ___ x 30 = ___ x months = ___ pounds ÷ 10 = ____ units.	T		
E0434RR	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or masks, tubing and refill		Use of portable liquid system must be based on a documented medical necessity with a physician's written prescription: 1. Diagnosis indicating client's ability to breathe is severely impaired. 2. Number of physician visits per month. 3. Length of time client will require oxygen. 4. Cost effectiveness of purchase versus rental must be documented. 5. Client must be using a stationary liquid oxygen system. No additional liquid is provided.	T		Liquid systems for mobility of the patient outside the home, such as a "stroller," are not a Medicaid benefit, unless a liquid stationary system has been approved. Other portable gas systems may be used to transport the patient to the physician's office. rental per month

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
E0450RR	Volume ventilator; stationary or portable					rental per month
E0601LL	Nasal continuous airway pressure (CPAP) device		Documentation of sleep-disordered breathing syndrome, including: 1. Sleep apnea with 10 episodes per hour 2. Respiratory failure with hypercapnia in the awake state (PCO2 greater than 45mm Hg) or Elevation of PCO2 during sleep of greater than 5mm Hg. above the awake state and to greater than 45mm Hg AND improvement in awake or sleeping PCO2 oxygen saturation, or related symptoms. These indications are secondary, but not limited to, the following: Chronic Obstructive Pulmonary Disease, Emphysema, Chronic Bronchitis, Bronchiectasis, Cystic Fibrosis, Obesity Hypoventilation Syndrome, Musculoskeletal Disorders, Kyphosis, Scoliosis, Kyphoscoliosis, Neuromuscular Disorders, Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Polio, Diaphragm Paralysis, Myotonic Dystrophy	W		rental per month Capped rental after 12 months, one per lifetime
E0618RR	Apnea monitor, without recording feature		COVERED UNDER CONTRACT ONLY: may not be billed directly to Medicaid			Rental per month
E0619RR	Apnea monitor, with recording feature		COVERED UNDER CONTRACT ONLY: may not be billed directly to Medicaid			Rental per month
E0480	Percussor, electric or pneumatic, home model					
E1355	Stand/rack for portable gaseous oxygen tanks					

	CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
*	K0531	Humidifier, heated, used with positive airway pressure device		Must be used in conjunction with air pressure device codes K0532 and K0533.	W		
	K0532RR	Respiratory assist device, bi-level w/o backup rate monitoring (BPAP-S)		Same criteria as E0601, Nasal continuous air way pressure (CPAP) PLUS additional documentation that the client cannot tolerate CPAP	W		
	K0533RR	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (Intermittent assist device with continuous positive airway pressure device) (BPAP-ST)		Same criteria as K0532, Respiratory assist device, bi-level with backup rt. PLUS additional documentation that the client cannot tolerate CPAP AND requires respiratory rate monitoring	W		
	S8185	Flutter device		1. Physician order. 2. Diagnosis of cystic fibrosis. 3. Lack of or inability of care giver to perform chest percussions. 4. More than one member of the family has diagnosis of cystic fibrosis.	W		
	E0445RR	Oximeter device for measuring blood oxygen levels non-invasively		1. Diagnosis: Oxygen dependent or weaning from oxygen, and recent (within 2 months) blood gas reports show decreased PO2, increased PCO2, PH, and bicarb abnormalities. 2. Respiratory Flow Sheets ● FIO2 (percentage of oxygen given) greater than 40 %. ● Fluctuating FIO2 or liter flows. ● SAO2 (saturation levels) 85% or less; wide variations which are not related to activity or explained by activity (i.e. crying). ● Respirations greater than 50 or 10 above child's norm. ● Heart rate greater than 110 or 10 above child's norm. 3. Doctor's prescription with diagnosis, length of time needed, saturation level to be maintained, oxygen percentage or liter flow to be delivered.	W		Per day: one unit Weekly rental bill for 7 units Monthly rental bill for 30/31 units
*	**E0434RR**	Portable liquid oxygen system, rental, includes portable system and supply		1. The patient's ability to breathe is severely impaired. 2. The physician prescribes appropriate oxygen therapy. 3. The physician's order as to specific medical need for the liquid, the liter flow, frequency (hours per day), and duration of oxygen therapy. 4. Specify the equipment being used. A liquid oxygen system will be approved only under specific circumstances, i.e., when multiple equipment is used in a series such as compressors, ventilators, etc.	T		Liquid systems for mobility of the patient outside the home, such as a "stroller," are not a Medicaid benefit, unless a liquid stationary system has been approved. Other portable gas systems may be used to transport the patient to the physician's office.

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A4618	Breathing circuits patient owned ventilator				y	1 every 5 months
E1390	Oxygen concentrator		Under contract to single provider only If supplying 4-back up e-tank bill with TW modifier.			rental per month

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ADDITIONAL OXYGEN RELATED SUPPLIES

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A4614	Peak expiratory flow rate meter, hand held					1 per year
A4615	Cannula nasal					
A4616	Tubing (oxygen), per foot					
A4617	Mouth piece					

HUMIDIFIERS and NEBULIZERS

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2 - 7, Oxygen and Related Respiratory Equipment s; Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
A4621	Tracheotomy mask or collar					
A4622	Tracheostomy or laryngectomy tube					1 per month
A4623	Tracheostomy, inner cannula (replacement only)					
A4625	Tracheostomy care or cleaning starter kit					1 per month
A4626	Tracheostomy cleaning brush, each					
S8189	Misc. tracheostomy supplies		ties, sponges, gauze	Y		one month supply
A7017LL	Nebulizer, bottle type, not used with oxygen					
A7501	Tracheostoma valve, including diaphragm, each					1 per month
E0550 P or LL	Humidifier, durable for extensive supplement humidification during IPPB treatments or oxygen delivery					For example, Cascade, rental per month
E0555 P or LL	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter					rental per month
E0565 P or LL	Compressor, air power source for equipment which is not self-contained or cylinder driven					rental per month
E0570 P or LL	Nebulizer, with compressor					For example, Devilbiss Pulmo-Aid rental per month
E0574LL	Ultrasonic/electronic aerosol generator with small volume nebulizer					rental per month
E0575 P or LL	Nebulizer, ultrasonic, large volume					rental per month
E0580 LL	Nebulizer, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter					rental per month
E0585LL	Nebulizer, with compressor and heater					rental per month
E1353	Regulator					1 every 5 years
K0268 LL	Humidifier, non-heated, used with Positive airway pressure					rental per month
K0531 LL	Humidifier, heated, used with positive airway pressure device		must be used in conjunction with air pressure device codes K0532 and K0533.	W		
E0550LL	Humidifier, durable, glass or autoclavable type, for use with regulator or flowmeter					rental per month
A7005	Administrations set, with small volume non-filled pneumatic nebulizer, non-disposable			W		limited to one unit
L8501	Tracheostomy speaking valve					

SUCTION PUMPS and ROOM VAPORIZERS

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	P A	LTC	COMMENT& LIMITS
A4610	Tracheal suction catheter, closed system, for more than 72 yours of use, each					12 per month
A4624	Tracheal suction catheter, any type other than closed system, each					100 per month
A4628	Oropharyngeal suction catheter, each					
E0600 P or LL	Respiratory suction pump, home model, portable or stationary, electric					rental per month
E0605	Vaporizer, room type (in home such as cool mist)					

MONITORING EQUIPMENT

Reserved for future use.

PATIENT LIFTS and TRACTION EQUIPMENT

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
E0630 P or LL	Patient lift, hydraulic, with seat or sling		Physician's order must document that the patient's diagnosis and severity of condition is such that the only alternative to the use of this device is bed confinement.	T		rental per month
E0840LL	Traction frame, attached to headboard, cervical traction					rental per month
E0860LL	Traction equipment, overdoor, cervical					rental per month
E0870 P or LL	Traction frame, attached to footboard, simple extremity traction (for example, Buck's)					rental per month
E0890 P or LL	Traction frame, attached to footboard, pelvic traction					rental per month
E0910 P or LL	Trapeze bars, as known as patient helper, attached to bed, with grab bar					rental per month
E0920LL	Fracture frame, attached to bed, includes weights		Fracture frame for attachment to bed requires Prior Authorization. The request for Prior Authorization and the physician's order must document that: 1. The patient is bed confined, and 2. The patient needs a trapeze bar to assist with elevating, to change the body position for other medical reasons, or to get in or out of bed.	T		rental per month
E0935RR	Continuous passive motion (CPM) exercise device		1. Only used post operatively for knee replacement 2. Must begin within 3 days of surgery. 3. Maximum of 21 days to include hospital days.	T		rental per week
E0942	Cervical head harness/halter		Physician's order	T		

WHEELCHAIR and WHEELCHAIR ACCESSORIES

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2 - 9, Wheelchairs; Chapter 3, LIMITATIONS

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
E0942	Cervical head harness/halter		Document medical necessity for head and neck support and restraint.	W		
E0944	Pelvic belt/harness/boot		Document medical necessity for pelvic support and restraint.	W		
E0950	Tray		Document medical necessity for support due to upper body weakness.	W		
E0951	Loop heel, each		Document medical necessity for heel support and restraint.	W		
E0952	Loop toe, each		Document medical necessity for toe support and restraint.	W		
E0953	Pneumatic tire, each		Documentation that medical condition of client is such that tires are necessary in client's residence as well as outside.	W		
E0954	Semi-pneumatic caster, each		Same as E0953 above	W		
E0961	Brake extension, for wheelchair		Documentation that medical condition of client requires extension for use of brakes.	W		
E0966	Hook on head rest extension		Documentation that client's medical condition requires head support.	W		
E0967	Wheelchair hand rims with 8 vertical rubber tipped projections, pair		Documentation that client's medical condition requires projections to facilitate self mobility.	W		
E0969	Narrowing device, wheelchair		Document medical necessity for support to client’s torso and hips for positioning and proper body alignment.	W		
E0970	No. 2 footplates, except for elevating leg rest		Replacement parts. Document medical necessity for foot support.	W		
E0971	Anti-tipping device wheelchairs		1. Physician order. 2. Diagnosis of spasticity, seizures 3. Letter of medical necessity	W		
E0972	Transfer board or device		Physician order PLUS any two of the following: 1. Inability to transfer by standing pivot. 2. Weak upper extremity strength, preventing self lifting for transfer. 3. Varied height of equipment involved in transfer.	W		
E0973	Adjustable height detachable arms, desk or full length, wheelchair		1. Diagnosis 2. Physician order specifying type of wheelchair 3. Severity of condition to justify 4. Patient would be bed or chair confined without a wheelchair 5. Prevent kyphosis, shoulder flexion or droop 6. Left and right side of body at different levels	W		1 every 5 years
E0974	"Grade-aid" (device to prevent rolling back on an incline) for wheelchair		1. Client has the potential to self-propel a manual wheelchair but has limited control for ramps and uneven surfaces. 2. Justification provides safety so that wheelchair does not roll backwards on an incline.	W		

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	L T C	COMMENT & LIMITS
E0976	Reinforced back, wheelchair, upholstery or other material		Document medical necessity for reinforcement of wheelchair back.	W		This code is NOT for re-upholstering.
E0977	Wedge cushion, wheelchair		Physician order and medically necessary for positioning	W		
E0978	Belt, safety with airplane buckle, wheelchair		1. Physician order 2. Client has weak upper body muscles 3. Certain muscle spasticities or lack of upper body stabilities	W		
E0979	Belt, safety with velcro closure, wheelchair		1. Physician order. 2. Client has weak upper body muscles 3. Certain muscle spasticities or lack of upper body stabilities	W		
E0980	Safety vest, wheelchair		1. Physician order. 2. Client has weak upper body muscles 3. Certain muscle spasticities or lack of upper body stabilities	W		
E0990 P or LL	Elevating leg rest, each		1. Physician order. 2. Leg injury or surgery 3. Improve circulation 4. Prevent contractures 5. Client has spasticity	W		
E0992	Solid seat insert		1. Physician order. 2. Orthopedic deformities 3. As a base for certain seating systems or heavy uses	W		
E0994	Arm rest, each		1. Physician order 2. Client has deformity which requires accommodation in position and support	W		
E0995	Calf rest, each		1. Physician order 2. Client has deformity which requires accommodation in position and support	W		
E0996	Tire, solid, each		Replacement for existing wheelchair.	W		
E1001	Wheel, single		Replacement for existing wheelchair	W		
E1013	Integrated seating system, contoured, for pediatric wheelchair		Contoured to patient body. Same criteria as Y6133, positioning cushion, gel system. Aductor pads, abductor pads or hip guides may be approved in addition, if there is medical necessity.	W		1 every 5 years
E1050 P or LL	Fully-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests		(Telephone PA if rental) 1. Diagnosis 2. Physician order specifying type of wheelchair 3. Severity of condition to justify: a. Pressure relief b. Fixed hip or leg angles c. For feeding or to deal with spasticity d. Orthopedic problems e. Assist with breathing f. Cardiac involvement	T or W		1 every 5 years if purchased

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
E1070 P or LL	Fully-reclining wheelchair, detachable arms, desk or full length swing away detachable foot rest		(Telephone PA if rental) 1. Diagnosis 2. Physician order specifying type of wheelchair 3. Severity of condition to justify: a. Pressure relief b. For feeding or to deal with spasticity d. Orthopedic problems e. Assist with breathing f. Cardiac involvement g. Required to prevent kyphosis or shoulder flexion or droop h. Right and left sides of body are required to be at different levels	T or W		1 every 5 years if purchased
E1088 P or LL	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable elevating leg rests		(Telephone PA if rental) 1. Diagnosis 2. Physician order specifying type of wheelchair 3. Severity of condition to justify 4. Documentation that client would be bed or chair confined without a wheelchair	T or W		This chair is for environmental challenges such as outdoor use, rough terrain. It is appropriate for clients with spinal cord injuries and older clients who have difficulty transferring. It is not appropriate for extended independent mobility.
E1092 P or LL	Wide heavy duty wheelchair, fixed full length arms, fixed or swing away detachable elevating leg rests		(Telephone PA if rental) 1. Diagnosis 2. Physician order specifying type of wheelchair 3. Severity of condition to justify 4. Documentation that client would be bed or chair confined without a wheelchair 5. Designed for overweight client	T or W		1 every 5 years

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
E1130 P or LL	Standard wheelchair, fixed full length arms, fixed or swing away detachable foot rests		(Telephone PA if rental) 1. Diagnosis 2. Physician order specifying type 3. Severity of condition to justify 4. Documentation client would be bed or chair confined without a wheelchair	T or W		This is a basic wheelchair. It is not appropriate for clients with permanent or long term disabilities.
E1140 P or LL	Wheelchair, detachable arms, desk or full length swing away detachable foot rests		(Telephone PA if rental) 1. Diagnosis 2. Physician order specifying type 3. Severity of condition to justify 4. Documentation client would be bed or chair confined without a wheelchair 5. Special positioning needs	T or W		
E1150 P or LL	Wheelchair, detachable arms, desk full or full length swing away-detachable elevating leg rests		(Telephone PA if rental) 1. Diagnosis 2. Physician order specifying type 3. Severity of condition to justify 4. Documentation that client would be bed or chair confined without a wheelchair 5. Special positioning needs	T or W		
E1160 P or LL	Wheelchair, fixed full length arms, swing away detachable- elevating leg rests		(Telephone PA if rental) 1. Diagnosis 2. Physician order specifying type 3. Severity of condition to justify 4. Documentation that client would be bed or chair confined without a wheelchair 5. Special positioning needs	T or W		
E1161	Manual Adult wheelchair, inc. Tilt in Space		Physician order Diagnosis that requires client to tilt to remove weight from spine and/or buttocks.	W		1 every 5 years
E1220	Wheelchair; specially sized or constructed		Indicate brand name, model number, if any justification	W		1 per lifetime
E1231	Wheelchair, Pediatric Size, Tilt-in-space, rigid, adjustable, with seating system	0-20	Physician order Diagnosis that requires client to tilt to remove weight from spine and/or buttocks.	W		1 every 5 years
E1232	Wheelchair, Pediatric Size, Tilt-in-space, folding, adjustable, with seating system	0-20	Physician order Diagnosis that requires client to tilt to remove weight from spine and/or buttocks.	W		1 every 5 years
E1233	Wheelchair, Pediatric Size;, Tilt-in-space, rigid, adjustable, without seating system	0-20	Physician order Diagnosis that requires client to tilt to remove weight from spine and/or buttocks.	W		1 every 5 years

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
E1234	Wheelchair, Pediatric Size;, Tilt-in-space, folding, adjustable, without seating system	0-20	Physician order Diagnosis that requires client to tilt to remove weight from spine and/or buttocks.	W		1 every 5 years
E1235	Wheel chair pediatric size, rigid, adjustable, with seating system	0-20				1 every 5 years
E1236	Wheel chair, pediatric, size, folding, adjustable with seating system	0-20				1 every 5 years
E1237	Wheel chair pediatric size, folding, adjustable, without seating system	0-20				1 every 5 years
E1238	Wheel chair, pediatric, size, folding, adjustable with seating system	0-20				1 every 5 years
E1240 P or LL	Lightweight wheelchair, detachable arms, desk or full length swing away elevating leg rests		1. Diagnosis 2. Physician order specifying type 3. Severity of condition to justify 4. Client or caregiver has strength and endurance (for mobility and lifting) 5. Positioning needs	T or W		Telephone PA if rental
E1260 P or LL	Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable foot rest		1. Diagnosis 2. Physician order specifying type 3. Severity of condition to justify 4. Client or caregiver has strength and endurance (for mobility and lifting) 5. Positioning needs	T or W		Telephone PA if rental
E1295 P or LL	Heavy duty wheelchair, fixed full length arms elevating leg rest		1. Diagnosis 2. Physician order specifying type 3. Severity of condition to justify 4. Documentation client would be bed or chair confined without a wheelchair. 5. Special positioning needs 6. Client is overweight or has reflex patterns which put extra stress on wheelchair	T or W		- Telephone PA if rental - 1 per lifetime
E1296	Special wheelchair seat height from floor		1. Physician order 2. Client has unusual body dimensions, and seat height appropriate to allow functional activities	T or W		Telephone PA if rental
E1297	Special wheelchair seat depth, by upholstery		1. Physician order 2. Client has unusual body dimensions 3. Orthopedic deformities 4. Seat depth appropriate for support to buttocks and thighs to prevent decubitus ulcers	T or W		Telephone PA if rental
E1298	Special wheelchair seat depth and/or width by construction		Same as E1297 above	T or W		

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
K0001LL	Standard wheelchair (no attachments)		Documentation of non-ambulatory			Rental by Month
K0002LL	Standard Hemi (low seat) wheelchair (no attachments)		Same at E1297 with documentation of need of low seat requirements			Rental by Month
K0003LL	Lightweight wheelchair (no attachments)		Physician order documentation of medical need for light weight			Rental by month
K0004LL	High Strength, lightweight wheelchair (no attachments)		Physician order Weight and activity of client.			Rental by month
K0006LL	Heavy duty wheel chair (no attachments)		Physician order documentation of medical need for heavy duty			Rental by month
K0007LL	Extra heavy duty wheelchair (no attachments)		Physician order Weight and activity of client.			Rental by month
K0065	Spoke protector, each					
K0108	Wheelchair component or accessory		1. Physician order 2. Description of component or accessory. 3. Description of medical condition which would require this addition.	W		
K0460	Power add-on, to convert manual wheelchair to motorized wheelchair, joystick control		1. Physician order 2. Physical therapist reviews, which includes written advice 3. Disability described: a. Required for home use (not outdoor travel) b. Has a manual wheelchair which is five years old or less c. Physician and physical therapist have documented that manual wheelchair is no longer adequate d. Projected use is for at least five years without requiring a new motorized chair	W		Payment is by invoice
K0461	Power add-on, to convert manual wheelchair to motorized wheelchair, tiller control		Same criteria as K0460 above.	W		Payment is by invoice
K0046	Foot rest extension tubes	0 - 20	Physician order	W		
K0048	Elevating foot rest extension tubes	0 - 20	Physician order	W		
E0997	Caster with a fork		1. Physician order 2. Patient owns equipment 3. Equipment is worn or broken from normal usage, not for lack of maintenance and not for patient abuse 4. Not on warranty.	W		
E0998	Caster without fork		1. Physician order 2. Patient owns equipment 3. Equipment is worn or broken from normal usage, not for lack of maintenance and not for patient abuse 4. Not on warranty.	W		
K0042	Standard size foot plate, each			W		
K0025	Hook on headrest extension			W		

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
E1210 **E1211** **E1212** **E1213**	Motorized wheel chair, fixed full length arms, swing away detachable leg rests and any additional attachments Motorized wheelchair, detachable desk or full length arms, detachable elevating leg rests. Motorized wheelchair, fixed full length arms, swing away detachable foot rests Motorized wheelchair, detachable desk or full length arms, detachable elevating foot rests.		To qualify for a motorized electric wheelchair, a client must meet all the criteria for a customized wheel chair (Y0662, Y0665) AND the additional criteria listed below. 1. Have a poor prognosis for ever being able to self-propel a functional distance. 2. Manifest the cognitive and physical ability necessary to operate a power driven wheelchair. 3. Demonstrate the ability to safely operate a power driven chair. A client of any age should have had a minimum of two hours instructions and use in an electric wheelchair. The physician and therapist documentation must indicate the patient's cognitive ability to operate the power chair. The patient must be able to manifest the physical, visual and mental ability to safely operate a wheelchair. The demonstrated medical necessity must be for use within the home or facility of residence. 4. The client and primary care giver(s) should have accepted or agree to accept education and training by a therapist to assist in adopting an attitude and fostering the expectation that the client will be allowed to be as independent as physically able. Documentation submitted must be current. a. Price list showing the catalog price of the base wheelchair, related components, and all attachments. Customized changes not specified in the catalog must be described on a separate form. b. Physician's order for the motorized wheelchair. c. A letter of medical need from the physician. The letter must include a detailed systems review of the client with the following information: (1) Medical diagnosis and prognosis; (2) Medical reasons for a motorized wheelchair; (3) The type of chair and attachments required by the client. d. An initial wheelchair evaluation from a registered physical therapist/occupational therapist (PT/OT). e. Copies of all warranties relating to the wheelchair. All wheelchairs must carry the maximum, most cost-effective warranty available.	W	Y	

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
Y0662	Customized wheelchair, pediatric design, fitting and assembly fee	20 & younger	A Medicaid client must meet all of the following criteria to qualify for a customized wheelchair. a. Be non-ambulatory (ability to walk only a few steps is considered non-ambulatory) or have a prognosis of not being able to ambulate within the next 12 months. b. Require a mobility aid to participate in normal daily activities in the home. c. Expect to have physical improvements, or the reduction of the possibility of further physical deterioration, from the use of a customized wheelchair; OR be for the necessary treatment of a medical condition. d. The client or primary care giver must be capable of maintaining the wheelchair or be capable of causing the wheelchair to be repaired and maintained. e. Repairs for a customized wheelchair require prior authorization. f. Must not currently own a medically appropriate type of chair for which reimbursement is being sought by Medicaid or must not have received a Medicaid reimbursed customized or motorized wheelchair within the previous five year period. g. Due to the federal requirements relating to non-duplication of services, a client who requires a customized or motorized wheelchair for continued employment, or a client who has a reasonable expectation for vocational development, must be referred to the Office of Rehabilitation Services in the Department of Education for an evaluation of eligibility for vocational rehabilitation services. Either the physician or the PT/OT may make the referral to Rehabilitation Services. Documentation submitted must be current. a. The Prior Approval Request Form must include the Medicaid codes for the wheelchair and each attachment with all relevant information. b. Physician's order for the wheelchair. c. A letter of medical need from the physician. The letter must include a detailed systems review of the client with the following information: (1) Medical diagnosis and prognosis; and (2) Medical reasons for wheelchair. d. All customized wheel chairs must be described in writing and identified by a HCPCS code. e. All accessories and attachments added to a wheelchair and costing more than $10.00 each must be described in writing and identified by the proper HCPCS code.	W		
Y0665	Customized wheelchair, adult design, fitting and assembly fee	21 & older		W		

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
* K0093	Rear wheel zero pressure tire tube (insert)			W		
K0097	Wheel zero pressure tire tube			W		
K0023	Solid back insert, planar back, single density foam		1. Physician order 2. Client has weak upper body muscles 3. Spinal deformities	W		
K0068	Pneumatic tire tube		Physician order which also documents a medical condition which requires pneumatic tires both inside and outside place of residence	W		2 every five years
K0104	Cylinder tank carrier					

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
Y6133	Gel positioning cushion system: with attachments		Must meet two of the following three criteria. 1. Is at risk for decubiti ulcer development and needs a gel-type cushion to prevent this condition, or 2. Has undergone a medical procedure of skin grafting and a gel-type cushion is required to maintain the integrity of the surgical intervention, or 3. Has special seating/positioning needs. Conditions for criteria 1 and 3 are listed in the next row.	W		

Conditions for criteria 1 (decubitus ulcer prevention):

A. Displays a diagnosis or condition which places person at risk for decubiti ulcer development which can include, but is not limited to the following conditions: (1) the lower torso, buttock, or lower extremities lack sensation (example- spina bifida, spinal cord injury, spinal tumors, etc.); (2) sensation is impaired (example--cerebral palsy, etc.); (3) the patient is significantly mentally impaired and unable to perform their own weight shifts(example. Profound mental retardation); (4) the upper extremities are impaired either through high tone (spasticity) or low tone/lack of strength so that arms cannot raise up total body weight against gravity (examples--cerebral palsy, muscular dystrophy, osteogenesis imperfecta).

B. Displays a diagnosis or condition which has required skin graft and gel cushioning required to maintain the medical procedure/surgical intervention. Include documentation WHY patient is unable to perform their own weight shifts, the prognosis for independence in weight shifts and/or further need for the type of cushion, and whether this is an area being addressed in the therapeutic treatment of the child.

Conditions for criteria 3 (special seating/positioning needs):

Displays the symptomatology requiring specialized seating needs which could include but is not limited to the following conditions: (1) hips are subluxed or dislocated, at risk for suluxation or dislocation, or to prevent a recurrent hip suluxation or dislocation (post-surgical procedure); (2) an abductor pummel is necessary to prevent hip adduction tendon tightening as a result of spasticity (commonly seen with cerebral palsy) and/or to maintain hip and lower extremity alignment post-surgical procedure (hip abductor lengthening); (3) low or no tone is present in the lower extremities so that alignment is necessary to prevent hip abduction (frog legged) positioning (common condition of hypotonia, spina bifida, spinal cord injury); (4) a neutral or anterior pelvic tilt cannot be achieved without specialized seating which could promote back/spinal deformities over time; (5) hips are asymmetrical, which may or may not be a result of back or spinal deformities, (spina bifida, scoliosis, kyphosis, etc.) requiring specialized seating to prevent further deformities; (6) leg length discrepancy where specialized seating can prevent asymmetrical posturing of hip and trunk and prevent later contractures; (7) specialized seating offers hip/leg protection necessary to prevent bone breakage/fracturing (example-osteogenesis imperfecta)

Code Y6133 include any specialized addition/modifications. Any additional wheelchair items such as Y6120, hip guides, and Y6130, Abductor pad, will NOT be approved in conjunction with either of these codes.

The treating therapist/providers must provide a statement indicating consideration of the lifespan of the requested cushion. The statement should reflect whether or not minor wheelchair modifications to the wheelchair back has taken place so that a slightly longer Jay cushion could be ordered which would accommodate the leg length growth of a child. Reasonable consideration of growth potential is expected.

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENT & LIMITS
* Y6144	Multi-chamber, air pocket, ROHO cushion		1. Physician order 2. Client has deformity which requires accommodation in position and support.	W		

WHEELCHAIR REPLACEMENT SUPPLIES

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 2 - 9, Wheelchairs; Chapter 3, LIMITATIONS

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTION	PA	LTC	LIMITS
A4631	Replacement, batteries for medically necessary electronic wheelchair owned by patient		Patient must own electric wheelchair	T	Y	2 batteries per year
K0082	22 NF non-sealed lead acid battery, each		Patient owns electric wheelchair	T	Y	2 batteries per year
K0083	22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)		Patient owns electric wheelchair	T	Y	2 batteries per year
K0085	Group 24 sealed lead acid battery, each (e.g., gel cell absorbed glass mat)		Patient owns electric wheelchair	T	Y	2 batteries per year

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REPAIRS AND DURABLE MEDICAL EQUIPMENT, NOT CLASSIFIED

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 3, LIMITATIONS; Chapter 7, REPAIRS and REPLACEMENT

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
E1340	Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes (for example, breaking down sealed components)		15 minutes equals one unit. This code does not cover routine maintenance, such as tire change, inspect chair, change batteries, etc.; nor repairs while the chair is in a warranty, nor if a rental. Document type of repair and time involved. Submit invoices with claim.	T		twelve (12) 15-minute units per calendar year.
E1399	Durable medical equipment, miscellaneous		1. Physician's letter of medical necessity and description of equipment. 2. Submit invoice or manufacturer's catalog showing retail price with claim. E1399, Durable Medical Equipment, miscellaneous, has required prior authorization since February 21, 2002. Medicaid expects this code to be used for small items (nuts, bolts, brackets, etc.) in the repair of DME and the occasional use for DME items for which there are no HCPCS codes, but which are medically necessary and which will sometimes occur in the CHEC program for children. This code should not be used for component parts for wheelchairs and as a code for generalized miscellaneous DME use. These situations will require the use of HCPCS codes as listed in the Medicaid Medical Supplies Manual. If there is no code, the item may not be a covered benefit.	W		3 per year, for medically necessary replacement items for patient-owned equipment.

PNEUMATIC COMPRESSOR and APPLIANCES

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 3, LIMITATIONS

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
E0651RR	Pneumatic compressor, segmental home model (lymphedema pump) without calibrated gradient pressure		Physician documentation that the client suffers from intractable lymphedema of the extremities. Documentation should contain information as to forms of therapy that have been tried unsuccessfully.	W		rental per month
E0652RR	Pneumatic compressor, segmental home model (lymphedema pump) with calibrated gradient pressure		Physician documentation that the client suffers from intractable lymphedema of the extremities. Documentation should contain information as to forms of therapy that have been tried unsuccessfully.	W		rental per month
E0667 P or RR	Segmental pneumatic appliance for use with segmental pneumatic compressor, full leg			W		rental per month
E0668 P or RR	Segmental pneumatic appliance for use with pneumatic compressor, full arm			W		rental per month
E0671 P or RR	Segmental gradient pneumatic appliance, full leg			W		rental per month
E0672 P or RR	Segmental gradient pneumatic appliance, full arm			W		rental per month

CERVICAL

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
E0701	Helmet with face guard and soft interface material, prefabricated	0-20	EPSDT	W		
L0120	Cervical, flexible, non-adjustable (foam collar)					
L0140	Cervical, semi-rigid, adjustable (plastic collar)					
L0174	Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension				Y	1 every 5 years

SPINAL, THORACIC LUMBAR SACRAL

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L0210	Thoracic, rib belt, custom fitting				Y	
L0454	TLSO flexible, provides truck support, extends from sacrococcygeal junction to above T-9 vertebra				Y	1 every 5 years
L0460	TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells				Y	1 every 5 years
L0472	TLSO, triplanar control, hyperextension, rigid anterior and lateral frame				Y	1 every 5 years
L0484	TLSO, triplanar control, two piece rigic plasstic shell without interface liner, custom fabricated				Y	1 every 5 years
L0486	TLSO, triplanar control, two piece rigid plastic shell with interface liner, custom fabricated.				Y	1 every 5 years

SPINAL, LUMBAR SACRAL

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L0500	Lumbar-sacral-orthosis (LSO), flexible, (lumbar-sacral support)				Y	1 every 5 years
L0510	LSO, flexible (lumbo-sacral support), custom fabricated				Y	1 every 5 years
L0520	LSO, anterior-posterior-lateral control (Knight, Wilcox types) with apron front				Y	1 every 5 years

SPINAL, SACROILIAC

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L0600	Sacroiliac, flexible (sacroiliac surgical support) custom fitted				Y	1 every 5 years
L0610	Sacroiliac, flexible (sacroiliac surgical support), custom fabricated				Y	1 every 5 years

SCOLIOSIS, CERVICAL THORACIC LUMBAR

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L1060	Addition of CTLSO or scoliosis orthosis, thoracic pad				Y	1 every 5 years
L1210	Addition to TLSO, (low profile), lateral thoracic extension				Y	1 every 5 years
L1240	Addition to TLSO, (low profile), lumbar derotation pad				Y	1 every 5 years
L1300	Other, scoliosis procedure, body jacket molded to patient model				Y	1 every 5 years

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LOWER LIMB: HIP, KNEE, ANKLE

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS& LIMITS
L1600	Hip orthosis (HO), abduction control of hip joints, flexible, Frejka type with cover, prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1620	HO, abduction control of hip joints, flexible, (pavlik harness), prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1660	HO, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1730	Leg perthes orthosis, Scottish rite type, custom-fabricated				Y	1 every 5 years
L1800	Knee orthosis (KO), elastic with stays, prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1830	KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1832	KO, adjustable knee joints, positional orthosis, rigid support, prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1834	KO, without knee joint, rigid, custom-fabricated				Y	1 every 5 years
L1840	KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated to patient model				Y	1 every 5 years
L1850	KO, Swedish type, includes fitting and adjustment				Y	1 every 5 years
L1870	KO, double upright, thigh and calf lacers, custom-fabricated				Y	1 every 5 years
L1880	KO, double upright, non-molded thigh and calf cuffs/lacers with knee joints, custom fabricated				Y	1 every 5 years
L1902	Ankle-foot orthosis (AFO), ankle gauntlet, prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1904	AFO, molded ankle gauntlet, custom-fabricated				Y	1 every 5 years
L1906	AFO, multi-ligament ankle support, prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1910	AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment				Y	1 every 5 years
L1930	AFO, plastic or other material, prefabricated, includes fitting				Y	1 every 5 years
L1940	AFO, plastic or other material, custom-fabricated (molded to patient model)				Y	1 every 5 years
L1960	AFO, posterior solid ankle, molded to patient model, plastic, custom-fabricated				Y	1 every 5 years
L1970	AFO, plastic molded to patient model, with ankle joint, custom-fabricated				Y	1 every 5 years

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS& LIMITS
L1990	AFO, cable upright free plantar dorsiflexion solid stirrup, calf band/cuff (double bar "DK" orthosis), custom-fabricated				Y	1 every 5 years
L2000	Knee-ankle-foot-orthoses (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), custom-fabricated				Y	1 every 5 years
L2020	KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/ cuffs (double bar "AK"), custom-fabricated				Y	1 every 5 years
L2036	KAFO, full plastic, double upright, free knee, custom-fabricated.				Y	1 every 5 years
L2060	HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt, custom-fabricated.				Y	1 every 5 years
L2080	HKAFO, torsion control, unilateral torsion cable hip joint, pelvic band/belt, custom-fabricated.				Y	1 every 5 years
L2627	Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables				Y	
L2640	Addition to lower extremity, pelvic control, band and belt, bilateral				Y	
L2800	Addition to lower extremity, knee control, knee cap, medial or lateral pull				Y	
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal, each				Y	
L5785	Addition, exoskeletal system, below knee, ultra-light material.		Doctor's order with diagnosis/ medical necessity for ultra light material, such as double amputee, child, or very small adult.	W	Y	

ADDITIONS TO LOWER EXTREMITY: ORTHOSES

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L2108	Ankle-foot orthosis (AFO), fracture orthosis, tibial fracture cast orthosis, custom-fabricated				Y	
L2136	Knee-ankle-foot-orthoses (KAFO), fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment				Y	
L2220	Addition to lower extremity, dorsiflexion and plantar flexion assist/resist each joint				Y	
L2230	Addition to lower extremity, split flat caliper stirrups and plate attachments				Y	
L2250	Addition to lower extremity, foot plate, molded to patient model, stirrup attachment				Y	
L2260	Addition to lower extremity, reinforced solid (Scott-Craig type)				Y	
L2270	Addition to lower extremity, varus/valgus correction ("T") strap, padded/lined or malleolus pad				Y	
L2280	Addition to lower extremity, molded inner boot				Y	
L2310	Addition to lower extremity, abduction bar-straight				Y	
L2340	Addition to lower extremity, pre-tibial shell, molded to patient model				Y	
L2405	Addition to knee joint, drop lock, each joint				Y	
L2415	Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint				Y	
L2500	Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring				Y	
L2540	Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model				Y	
L2580	Addition to lower extremity, pelvic control, pelvic sling				Y	
L2600	Addition to lower extremity, pelvic control, hip					
L2610	Addition to lower extremity, pelvic control, hip joint, pelvis or thrust bearing, lock, each				Y	
L2620	Addition to lower extremity, pelvic control , hip joint, heavy duty, each				Y	
L2630	Addition to lower extremity, pelvic control unilateral				Y	
L2640	Addition to lower extremity, pelvic control, band and belt, bilateral				Y	
L2650	Addition to lower extremity, pelvic and thoracic control, gluteal pad, each				Y	
L2660	Addition to lower extremity, thoracic control, thoracic band				Y	
L2670	Addition to lower extremity, paraspinal uprights				Y	
L2680	Addition to lower extremity, thoracic control, lateral support uprights				Y	
L2800	Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull				Y	
L2860	Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism, each				Y	
L4350	Pneumatic ankle control splint, prefabricated, includes fitting and adjustment				Y	

FOOT ORTHOPEDICS: SHOE and MODIFICATIONS

References: SECTION 2, Medical Supplies, Chapter 2, SCOPE OF SERVICE

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L3140	Foot, abduction rotation bar, including shoes				Y	1 every 5 years, or 2 in 5 years if applicable for both legs or feet.
L3150	Foot, abduction rotation bar, without shoes				Y	Dennis Browne type
L3600	Transfer of an orthosis from one shoe to another, caliper plate, existing				Y	
L3610	Transfer of an orthosis from one shoe to another, caliper plate, new				Y	2 per year
L3620	Transfer of an orthosis from one shoe to another, solid stirrup, existing				Y	2 per year
L3640	Transfer of an orthosis from one shoe to another, Dennis Browne splint (Riveton), both shoes				Y	2 per year
* **L3224**	Orthopedic Footwear, Female shoe, used as part of a brace	0-20	Doctor's order with diagnosis of medical necessity 1. When attached to a brace or prosthesis, or 2. When especially constructed to provide for a totally or partially missing foot.	T	Y	2 every 6 months
L3225	Orthopedic Footwear, male shoe, used as part of a brace					
A5507	Diabetics only, modification of a shoe (includes fitting),	21 & older	Same as code L3224		Y	2 per 6 months

UPPER LIMB

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L3650	Shoulder orthosis (SO), figure of "8" design abduction restrainer, prefabricated, includes fitting and adjustment				Y	1 per year
L3670	SO, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment				Y	1 per year
L3675	SO, vest type abduction restrainer, canvas webbing type or equal, prefabricated, includes fitting and adjustment		1. Diagnosis or description of disability 2. No other ankle has been provided within a year 3. Medical necessity for shock absorbing ankle identified	T	Y	1 every 5 years
L3700	Elbow orthoses (EO), elastic with stays, prefabricated, includes fitting and adjustment				Y	
L3800	Wrist-hand-finger-orthoses (WHFO), short opponens, no attachments, custom-fabricated.				Y	
L3908	Wrist-hand-finger-orthoses (WHFO), wrist extension control cock-up, non-molded, prefabricated, includes fitting and adjustment				Y	
L3980	Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment				Y	
L3982	Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment				Y	
L3986	Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist (example: colles fracture), custom-fabricated.				Y	
L3890	Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism, each				Y	

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ORTHOTIC REPAIRS

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 3, LIMITATIONS; Chapter 7, REPAIRS and REPLACEMENT

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L4205	Repair of orthotic device, labor component, per 15 minutes			T	Y	twelve (12) 15-minute units OR 3 hours per year
L4210	Repair of orthotic device, repair or replace minor parts				Y	3 per year

PROSTHETICS, LOWER LIMB

Reference: SECTION 2, Medical Supplies, Chapter 3, LIMITATIONS

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L5000	Partial foot, shoe insert with longitudinal arch, toe filler				Y	1 every 5 yearse
L5050	Ankle, Symes, molded socket, sach foot				Y	1 every 5 years
L5060	Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot				Y	1 every 5 years
L5100	Below knee, molded socket, shin, sach foot				Y	1 every 5 years
L5105	Below knee, plastic socket, joints and thigh lacer, sach foot				Y	1 every 5 years
L5200	Above knee, molded socket, single axis constant friction knee, shin, sach foot				Y	1 every 5 years
L5250	Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, sach foot				Y	1 every 5 years
L5311	Knee disarticulation (or through knee), molded socket, external knee joints, shin, sach foot, endoskeletal system				Y	1 every 5 years
L5321	Above knee, molded socket, open end, Sach foot, endoskeletal system, single				Y	1 every 5 years
L5331	Hip disarticulation, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot				Y	1 every 5 years
L5420	immediate post surgical or early fitting				y	1 every 5 years
L5450	Immediate post surgical or early fitting below knee				y	1 every 5 years
L5585	Preparatory, above knee-disarticulation, ischial level socket, "USMC" or equal pylon, no cover, sach foot, prefabricated adjustable open end socket				Y	1 every 5 years
L5590	Preparatory, above knee-knee disarticulation ischial level socket, "USMC" or equal pylon no cover, sach foot, laminated socket, molded to model				Y	1 every 5 years
L5614	Addition to lower extremity, above knee-disarticulation, 4 bar linkage, with pneumatic swing phase control				Y	1 every 5 years
L5618	Addition to lower extremity, test socket, Symes				Y	1 every 5 years
L5620	Addition to lower extremity, test socket, below knee				Y	1 every 5 years
L5622	Addition to lower extremity, test socket, knee disarticulation				Y	1 every 5 years
L5624	Addition to lower extremity, test socket, above knee				Y	1 every 5 years

	CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
	L5628	Addition to lower extremity, test socket, hemipelvectomy				Y	1 every 5 years
	L5629	Addition to lower extremity, below knee, acrylic socket				Y	1 every 5 years
	L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket				Y	1 every 5 years
	L5632	Addition to lower extremity, Symes type, "PTB" brim design socket				Y	1 every 5 years
	L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket				Y	1 every 5 years
	L5637	Addition to lower extremity, below knee, total contact				Y	1 every 5 years
	L5643	Addition to lower extremity, hip disarticulation, flexible inner socket				Y	1 every 5 years
	L5647	Addition to lower extremity, below knee suction socket				Y	1 every 5 years
	L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket				Y	1 every 5 years
	L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket				Y	1 every 5 years
	L5654	Addition to lower extremity, socket insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote, or equal)				Y	1 every 5 years
	L5655	Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote, or equal)				Y	1 every 5 years
	L5658	Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote, or equal)				Y	1 every 5 years
*	**K0556**	Addition to lower extremity, below/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism				Y	1 every 5 years
*	L5666	Addition to lower extremity, below knee, cuff suspension				Y	1 every 5 years
	L5668	Addition to lower extremity, below knee, molded distal cushion				Y	1 every 5 years
	L5670	Addition to lower extremity, below knee, molded supracondylar suspension (“PTS” or similar)				Y	1 every 5 years
	L5671	Addition to lower extremity, below knee, locking mechanism				y	1 every 5 years
	L5674	Addition to lower extremity, below knee, suspension any material, each				Y	1 every 5 years

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L5676	Addition to lower extremity, below knee, knee joints, single axis, pair		1. Where the stump is short and pulls out of the cuff of the prosthesis in ordinary, daily living activities; 2. Where the skin on the stump is sensitive or irritated and pressure must be relieved; 3. When the patient is pregnant and weight in the stump should be relieved. The approval will not be made when the reason given is that the patient's stump pulls out of the cuff during active sports or unusual activities not related to daily living, or because the patient merely desires a lacer.	T		Must be used with code L5680. 1 every 5 years
L5680	Addition to lower extremity, below knee, thigh lacer, non-molded		1. When the stump is short and pulls out of the cuff of the prosthesis in ordinary, daily living activities: 2. Where the skin on the stump is sensitive or irritated and pressure must be relieved: 3. When the patient is pregnant and weight in the stump should be relieved. The approval will not be made because the patient's stump pulls out of the cuff during active sports or unusual activities not related to daily living, or because the patient merely desires a lacer.	T		1 every 5 years
L5684	Addition to lower extremity, below knee, fork strap				Y	1 every 5 years
L5690	Addition to lower extremity, below knee, waist belt, padded				Y	1 every 5 years
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined				Y	1 every 5 years
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band				Y	1 every 5 years
L5698	Addition to lower extremity, above knee or knee disarticulation, silesian bandage				Y	1 every 5 years
L5700	Replacement, socket, below knee, molded to patient model				Y	1 every 5 years
L5701	Replacement, socket, above knee/knee disarticulation, including attachment, molded to patient model				Y	1 every 5 years
L5702	Replacement, socket , hip disarticulation, including hip joint, molded to patient model				Y	1 every 5 years
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock				Y	1 every 5 years
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phrase control (safety knee)				Y	1 every 5 years

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control				Y	1 every 5 years
L5785	Addition, exoskeletal system, below knee, ultra-light material		Doctor's order with diagnosis/ medical necessity for ultra light material, such as double amputee, child, or very small adult	T	Y	1 every 5 years
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock				Y	1 every 5 years
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)				Y	1 every 5 years
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control				Y	1 every 5 years
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist				Y	1 every 5 years
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist				y	1 every 5 years
L5910	Addition, endoskeletal system, below knee, alignable system				y	1 every 5 years
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable Doctor's order with diagnosis/ medical necessity for ultra light material, such as double amputee, child, or very small adult.				Y	1 every 5 years
L5925	Addition, endoskeletal system, above knee, knee or hip disarticulation, manual lock				Y	1 every 5 years
L5940	Addition, endoskeletal system, below knee, ultra light material (titanium, carbon fiber or equal)		Doctor's order with diagnosis/ medical necessity for ultra light material, such as double amputee, child, or very small adult.	T	Y	1 every 5 years
L5950	Addition, endoskeletal system, above knee, ultra light material (titanium, carbon fiber or equal)		Doctor's order with diagnosis/ medical necessity for ultra light material, such as double amputee, child, or very small adult	T	Y	1 every 5 years
L5968	All lower extremity prostheses, ankle, multiaxial shock absorbing system		Physician ordered Diagnosis or description of disability No other ankle has been provided within a year Medical necessity for shock absorbing ankle identified	T	Y	1 every 5 years
L5970	All lower extremity prostheses, foot, external heel, sach foot				Y	1 every 5 years
L5972	All lower extremity prostheses, flexible heel foot (safe, sten, bock dynamic or equal)				Y	1 every 5 years

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L5974	All lower extremity prostheses, foot, single axis ankle/foot				Y	1 every 5 years
L5976	All lower extremity prostheses, energy storing foot (Seattle carbon copy II or equal)				Y	1 every 5 years
L5978	All lower extremity prostheses, foot multiaxial ankle/foot (Griesinger or equal)				Y	1 every 5 years
L5979	All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system				Y	1 every 5 years
L5980	All lower extremity prostheses, flex foot system				Y	1 every 5 years
L5982	All exoskeletal lower extremity prostheses, axial rotation unit				Y	1 every 5 years
L5984	All endoskeletal lower extremity prostheses, axial rotation unit				Y	1 every 5 years
L5986	All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal)				Y	1 every 5 years

UPPER LIMB: MEDICAL SUPPLIES

Reference: SECTION 2, Medical Supplies, Chapter 3, LIMITATIONS

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	P A	LTC	COMMENTS & LIMITS
L6000	Partial hand, robin-aids, thumb remaining (or equal)				Y	
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad				Y	
L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad				Y	
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm				Y	
L6310	Shoulder disarticulation, passive restoration (complete prosthesis)				Y	
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping				Y	
L6675	Upper extremity additions, harness, figure of ("8") eight type, for single control				Y	
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow				Y	
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic				Y	
L6725	Terminal device, hook, dorrance, or equal, model #7				Y	
L6830	Terminal device, hand, APRL, VC				Y	

REPAIR PROSTHETIC DEVICE

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 3, LIMITATIONS; Chapter 7, REPAIRS and REPLACEMENT

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L7500	Repair of prosthetic device, hourly rate				Y	3 hours per year
L7510	Repair of prosthetic device, repair or replace minor parts				Y	3 per year
L7520	Repair of prosthetic device, labor component, per 15 minutes			T or W		2 hours per year

BREAST PROSTHETICS

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L8000	Breast prothesis, mastectomy bra				Y	
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral				Y	
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral				Y	
L8020	Breast prothesis, mastectomy form				Y	
L8030	Breast prothesis, silicone or equal				Y	

PROSTHETIC SOCK

References: SECTION 2, Medical Supplies, Chapter 5, SUPPLIES FOR PATIENTS IN A LONG TERM CARE FACILITY

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
L8400	Prosthetic sheath, below knee, each					
L8410	Prosthetic sheath, above knee, each					
L8420	Prosthetic sock, multiple ply, below knee, each					
L8430	Prosthetic sock, multiple ply, above knee, each					
L8435	Prosthetic sock, multiple ply, upper limb, each					
L8440	Prosthetic shrinker, below knee, each				Y	
L8460	Prosthetic shrinker, above knee, each				Y	
L8470	Prosthetic sock, single ply, fitting, below knee, each					
L8480	Prosthetic sock, single ply, fitting, above knee, each					
L8485	Prosthetic sock, single ply, fitting, upper limb, each					

EYE PROSTHESIS

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
V2623	Prosthetic eye, plastic, custom				Y	
V2624	Polishing / resurfacing of ocular prosthesis				Y	

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HEARING AIDS

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 7, REPAIRS and REPLACEMENT

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
V5130	Hearing Aid Binaural, ITE, Global charge		Same as V5248			Same as V5248
V5140	Hearing Aid Binaural, BTE, Global charge		Same as V5248			Same as V5248
V5242	Hearing aid, analog, monaural, CIC, Global charge		1. **For clients 18 years through 20 years** Average hearing loss in one ear of 35 dB or greater, based on the PTA for that ear. 2. **For clients 17 years and younger:** Average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, 4000 hertz. NOTE: Two monaural hearing aids cannot be dispensed as an alternative to one binaural. Bill a monaural aid as quantity one only.			Code includes conformity evaluation and ear molds. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
V5243	Hearing aid, analog, monaural, ITC, Global charge		Same criteria as for V5242.			Same as for V5242.
V5248	Hearing aid, analog, binaural, CIC		1. **For clients 18 years through 20 years,** the criteria is either: a. Average hearing loss in both ears of 30 dB or greater, or b. The recipient is blind and a monaural hearing aid may be contraindicated. 2. **For clients 17 years and younger,** the criteria is either: a. Average hearing loss of 25 dBs, based on a high frequency PTA specially calculated for frequencies 1000, 2000, 4000 in both ears; or b. The recipient is blind, and a monaural hearing aid may be contraindicated. Bill a binaural aid as quantity ONE only. Do not bill for quantity two; only quantity one of the binaural procedure code is available for reimbursement.			Code includes conformity evaluation and ear molds. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
V5249	Hearing aid, analog, binaural, ITC		Same as V5248.			Same as V5248.
V5050	Hearing Aid, monaural, ITE, Global charge		Same criteria as for V5242.			Same as for V5242

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
V5254	Hearing aid, digital, monaural, CIC		Digital hearing aids do not include digitally programable hearing aids. Covered for children age six and under who meet criteria for regular hearing aids. If over age six, the child may qualify for a digital hearing aid when He/she meets criteria for regular hearing aids and has a language age less than six years as measured by standard tests, such as Receptive One Word Picture Vocabulary Test. Two devices may be authorized for binaural applications.			Code includes conformity evaluation and ear molds. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
V5255	Hearing aid, digital, monaural, ITC		Same as V5254			Same as V5254
V5256	Hearing aid, digital, monaural, ITE		Same as V5254			Same as V5254
V5257	Hearing aid, digital, monaural, BTE		Same as V5254			Same as V5254
V5060	Hearing Aid, monaural, BTE, Global charge		Same criteria as for V5242			Same as for V5242
V5266	Battery for use in hearing device		Specify type such as zinc air, as well as the number.			Six per month for a monaural aid. Twelve per month for binaural aids.
V5266	Hearing aid loaner		While hearing aid is being repaired or assessing an infant or toddler prior to purchase of hearing aid.	W	Y	2 month maximum

HEARING AID REPAIRS

References: SECTION 2, Medical Supplies, Chapter 1, MEDICAL SUPPLIES; Chapter 7, REPAIRS and REPLACEMENT

CODE	DESCRIPTOR	AGE	CRITERIA & INSTRUCTIONS	PA	LTC	COMMENTS & LIMITS
V5014	Repair/modification of a hearing aid		Submit itemized invoice. Includes time, handling, and parts.		W	

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